North East **LHIN**

Integrated Health Service Plan 2013-2016

Quality Health Care When NORTHERNERS Need It

Ontario

North East Local Health Integration Network

North East Local Health Integration Network

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Cover photo: North East LHIN CEO Louise Paquette with octogenarian Leo Hart who holds a piece of the ribbon that was cut to open his new home – the Lepokoti residence at Finlandia Village. This new 82-unit home in Sudbury offers assisted living services for high-risk seniors.

Published February, 2013

NE LHIN Vision

Quality health care, when you need it.

NE LHIN Mission

To advance the integration of health care services across Northeastern Ontario by engaging our communities.

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Executive Summary

The North East Local Health Integration Network's (NE LHIN) 2013-2016 Integrated Health Service Plan (IHSP) focuses on strategies to integrate and realign the local health care system to better care for Northerners, particularly our region's seniors and frail elderly.

"More than 4,000 Northerners actively participated in engagement efforts to put this plan together."

- Louise Paquette, Chief Executive Officer, North East LHIN

Our priorities result from extensive and solution-focused community engagements, and reflect what thousands of Northerners have said they need and want to live healthy and well in Northeastern Ontario.

NE LHIN CEO Louise Paquette helps one of the children visiting the Elders Gathering Place in Moosonee. Children visit the elders weekly at the Gathering Place, one of the adult day programs funded by the North East LHIN.

Northern voices are the bedrock of this IHSP.

Northerners told us they want:

- Increased access to primary care services;
- Fewer gaps in services and an easy-to-follow care plan when they are discharged from hospital;
- More community-based care and home services, particularly for our region's seniors and frail elderly who are growing in number;
- Providers working together to determine the services people need;
- Better coordinated mental health and substance abuse treatment services that are easier to find and closer to home; and
- Health care services that recognize our region's cultural diversity.

We responded. Northerners expect and deserve no less.

This IHSP includes specific actions that will be taken to achieve the goals of each of our four priorities over the next three years, and how we will measure our work. We will continue to collaborate with partners to move our health system from provider- to patient-centred, and ensure outcomes and evidence drive quality care. We will work to advance our gains and hold both ourselves and health service providers accountable to measurable outcomes.

Provincial Context

Working with the Ministry of Health and Long-Term Care, LHINs ensure that local and regional plans align with provincial priorities for the health care system to improve access to care and ensure sustainability. LHINs are responsible for the allocation of about half of the province's health care expenditures, or about $22 billion in funding as of 2011[1].

Between 2003-04 and 2011-12, health sector funding in the provincial budget increased at an average rate of about 6% annually, for a total increase of $17.9 billion. However, the province faces substantial fiscal pressures. In an effort to reduce expenditure growth to ensure sustainability and manage those challenges, the government has stated that "funding for the health care system cannot continue to grow at past rates."[2] This will require getting better value for money from all parts of the health care system to maintain access to services and continue to improve the quality of care.

A key driver of future health care costs – in addition to general inflation and changes in technology – and a factor in the sustainability of the system is the fact that the population of Ontario is getting older and as people age they require more health care. Specifically, in ten years there will be 43% more seniors in the province than there are now and in twenty years there will be twice as many[3]. Without changing how we deliver care in Ontario, in 20 years the health care system would cost $24 billion dollars more per year than we spend now[4]. Therefore, Ontario's LHINs are planning for changes to the health care system that support delivering the right care in the right place, promote value for the dollar and ensure that resources are used sustainably.

With a mandate to engage with the public, health care providers and other stakeholders, LHINs are uniquely positioned to address these fiscal, demographic and technological challenges.

The Honourable Deb Matthews, Minister of Health and Long-Term Care, attended a Northeastern Seniors' Fair and learned about the wide range of community-based programs and services that are making a difference in meeting the needs of our region's seniors and frail elderly. Alice Menard (left) and Sandra Doucette (right) shared the work of the Ontario March of Dimes with the Minister. Each year, the NE LHIN provides funding to the Ontario March of Dimes to deliver health care in communities across the region, including congregate care, independence training, and other services that are helping people with acquired brain injuries live independently longer.

Provincial Priorities

In January 2012, the province unveiled ***Ontario's Action Plan for Health Care*** to meet the challenge of managing spending growth while continuing to provide high-quality care to all Ontarians.

The Action Plan identifies three focus areas: (1) **Keeping Ontario Healthy; (2) Faster Access and a Stronger Link to Family Health Care; (3) Right Care, Right Time, Right Place.**

Keeping Ontario Healthy focuses on helping people stay healthy by supporting habits and lifestyle changes. In addition to tackling childhood obesity, smoking and cancer screening, the province continues to work on better management of chronic conditions, such as diabetes.

Faster Access and a Stronger Link to Family Health Care are the centre of the health care system for most people. A family physician or health care team is ideally the first point of contact with the system when someone needs help, unless it is an emergency. Ontario's Action Plan identifies faster access to primary care, more ways to access family health care resources, such as telemedicine points of contact and quality measures to family health

[1] Estimates, 11/12
[2] 2012 Provincial Budget, page 23
[3] Ontario's Action Plan for Health Care, P. 7
[4] Ontario's Action Plan for Health Care, P. 7

care. The goal is to ensure appropriate care from family care providers, to deliver right care in the right place at the right time, and help reduce hospital readmissions.

Right care means care informed by what the best scientific evidence and clinical guidelines have determined is the best care for you. It eliminates unnecessary procedures and tests, making resources available for those who need them most. The province and the LHINs are working with Health Quality Ontario to translate evidence into tools and guidelines that can help providers put patient-centred and evidence-based care into practice.

Care at the right time means having faster access to the care you need. This could mean telemedicine or supports to help you stay at home longer, in your community close to your family and friends. This priority also means a renewed emphasis on preventative and proactive care so chronic conditions are managed, reducing the number of hospitalizations a person requires, easing the strain in emergency rooms and inpatient beds.

Care in the right place addresses several serious issues in the health care system. One of the most pressing is the challenge of Alternate Level of Care (ALC) patients, who are in hospital beds, but would be best cared for in the community with support services to help maintain and improve their quality of life. Community care costs a fraction of what it costs to keep a patient in a hospital bed, once the acute phase of care is completed.

To support the Action Plan's goal of providing more community-based care for seniors, the 2012 provincial budget increased funding for home and community services over the next three years[5]. Hospital base-budgets were frozen and only 2 per cent increase in funding will take place for certain activity-based initiatives, such as targeted wait-times reductions and priority treatments.

Changes in the funding of traditional health care providers in the system and hospitals are helping to make the system more patient-centred. LHINs are working with hospital and community partners to transition procedures out of the high cost hospital setting into non-profit community-based clinics. Hospital base-budgets are being transitioned into a patient-centred funding model where the provider is rewarded for high-quality care and better use of resources.

An additional change to the health care system was the launch of a provincial Seniors Strategy, January 2013. This strategy builds on the successes of the Aging at Home program and will help to drive system change to reflect the demographic shift across the province.

LHIN System Imperatives

To align the high-level goals of the Action Plan with their IHSPs, Ontario's LHINs have developed four system imperatives.

Enhancing Access to Primary Care
Enhancing Coordination & Transitions of Care for Targeted Populations
LHIN System Imperatives
Implementing Evidence Based Practice to Drive Quality and Safety
Holding the Gains

Enhancing Access to Primary Care helps ensure people have timely access to a primary care provider. It also supports the appropriate use of hospital and clinical resources.

Enabling Coordination and Transitions of Care for Targeted Populations focuses on key populations of "high-needs" patients and those at risk of becoming "high-needs" patients.

Implementing Evidence-Based Practice to Drive Quality and Safety supports consistent, coordinated responses to high-priority safety issues.

Holding the Gains helps LHINs make sound choices about local projects and ensures achievements made to date are not lost as new priorities are developed.

[5] 2012 Ontario Budget, page 28

Northeastern Ontario Context

The NE LHIN has 185 Accountability Agreements which hold health care service providers accountable to deliver $1.4 billion in front-line health care each year. These agreements include:

- 118 Multi Sector Service Accountability Agreements (M-SAAs)
- 25 Hospital Service Accountability Agreements (H-SAAs)
- 42 Long-Term Care Service Accountability Agreements (L-SAAs)

The NE LHIN spans 400,000 square km and represents over 40% of the province's land area and just over 4.2% of the population. Between 2006 and 2011, the population in the NE LHIN remained relatively stable, in comparison to a provincial growth rate of 5.6%.

Given the geographic size and the diversity of Northeastern Ontario (approximately 22% Francophone, close to 10% Aboriginal/First Nation/Métis), five HUB planning areas have been created within the region based on hospital referral patterns. The development of these geographic areas is intended to enhance planning and community engagement, particularly in enhancing access to care as close to home as possible.

Information in this profile was extracted from the *Common Environmental Scan* found in Appendix C.

Hub Planning Area	Total Population	% of NE LHIN
Algoma	115,870	20.95
Cochrane	76,856	13.90
James Bay & Hudson Bay Coasts	6,213	1.12
Nipissing & Temiskaming	117,370	21.22
Sudbury, Manitoulin & Parry Sound	236,782	42.81
NE LHIN Region	553,091	100

(2011 Census, Statistics Canada)

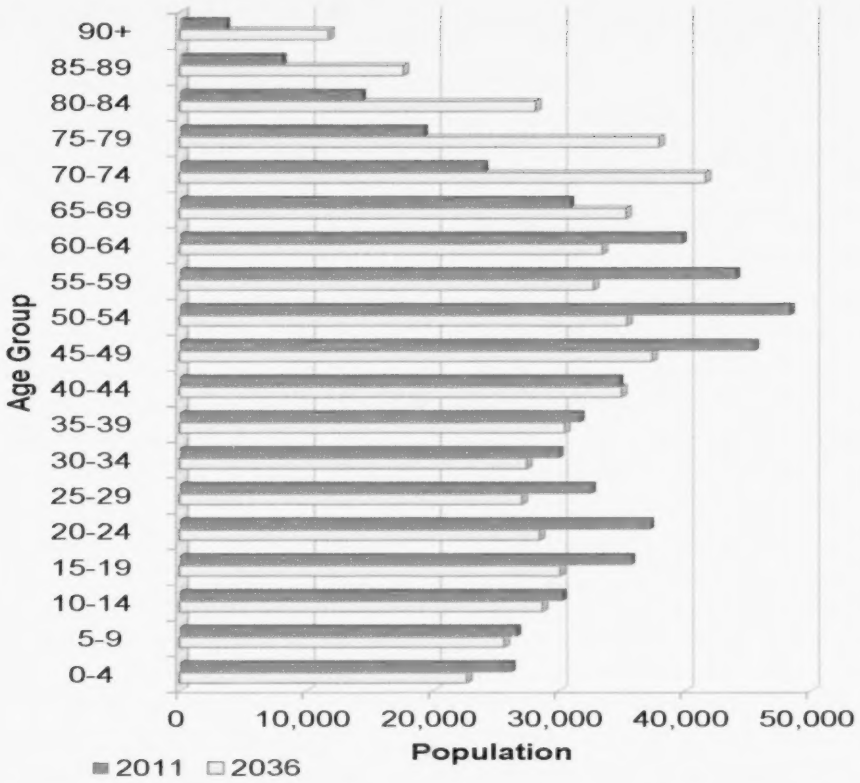
Access to Health Services

- The NE LHIN has 538 Family Physicians, one Group Health Centre in Sault Ste. Marie (34 family physicians), 27 Family Health Teams, six Community Health Centres, six Nurse Practitioner-Led Clinics, 16 Nursing Stations and three Aboriginal Health Centres.
- The Health Care Connect Program began in February 2009 in Ontario and has helped Northerners connect with primary care providers. Between February 2009 and October 2012, 42,283 NE LHIN residents had registered with the program and nearly 70% had been referred to a family health care provider.
- In the NE LHIN there are 108 long-term care beds for every 1,000 people aged 75 and over (2012), as compared to 86 beds per 1,000 people aged 75 and over in Ontario.

Life Span

- Both male and female NE LHIN residents have a shorter life expectancy than residents of Ontario: 76.5 years for males (79.2 years in Ontario), and 81.4 years for females (83.6 in Ontario).
- The leading causes of death for NE LHIN residents, as well as all Ontarians, are circulatory system diseases (such as heart disease and strokes) and neoplasms (cancer). The rate of circulatory system disease deaths (deaths per 100,000 population) are 22% higher in the NE LHIN than in Ontario; and neoplasms are 16% higher.
- Premature mortality, a measure of death rates (per 100,000 population) prior to age 75, is 26% higher in the NE LHIN compared to the province.

Population Change



The NE LHIN population is projected to change dramatically over the next 25 years. The proportion of the population aged 65 and over is projected to increase from 18% to 30% by 2036. The estimated number of seniors (65+) is projected to increase by 72%, from just over 100,000 to over 172,000 (note the provincial average is expected to increase by about 67%). This significant demographic shift has major implications on the delivery of health care and the type and location of services delivered.

The overall NE LHIN population is projected to increase by only 1% between 2011 and 2036 (2011 population Census data - Ministry of Finance population projections).

Overall, compared to the province, the North East has a higher:

	North East LHIN	Ontario*
Proportion of Aboriginal Identity	9.5%	2.0%
Proportion of Francophones	22%	4.4%
Proportion of people living in rural areas	30.2%	14.1%
Proportion of people over the age of 65	18%	14.6%
Unemployment rate for ages 15+	8.4%	6.4%
Proportion age 25 and over who do not have a post-secondary degree, diploma or certificate	18.4%	13.5%
Percentage of smokers	25.4%	19%
Percentage of drinkers reporting heavy drinking	19.9%	16.2%
Percentage of adults (age 18+) who are overweight or obese	61.7%	52.3%
Prevalence of high blood pressure	22.5%	17.4%
Percentage of residents with multiple chronic conditions	21.5%	15.2%

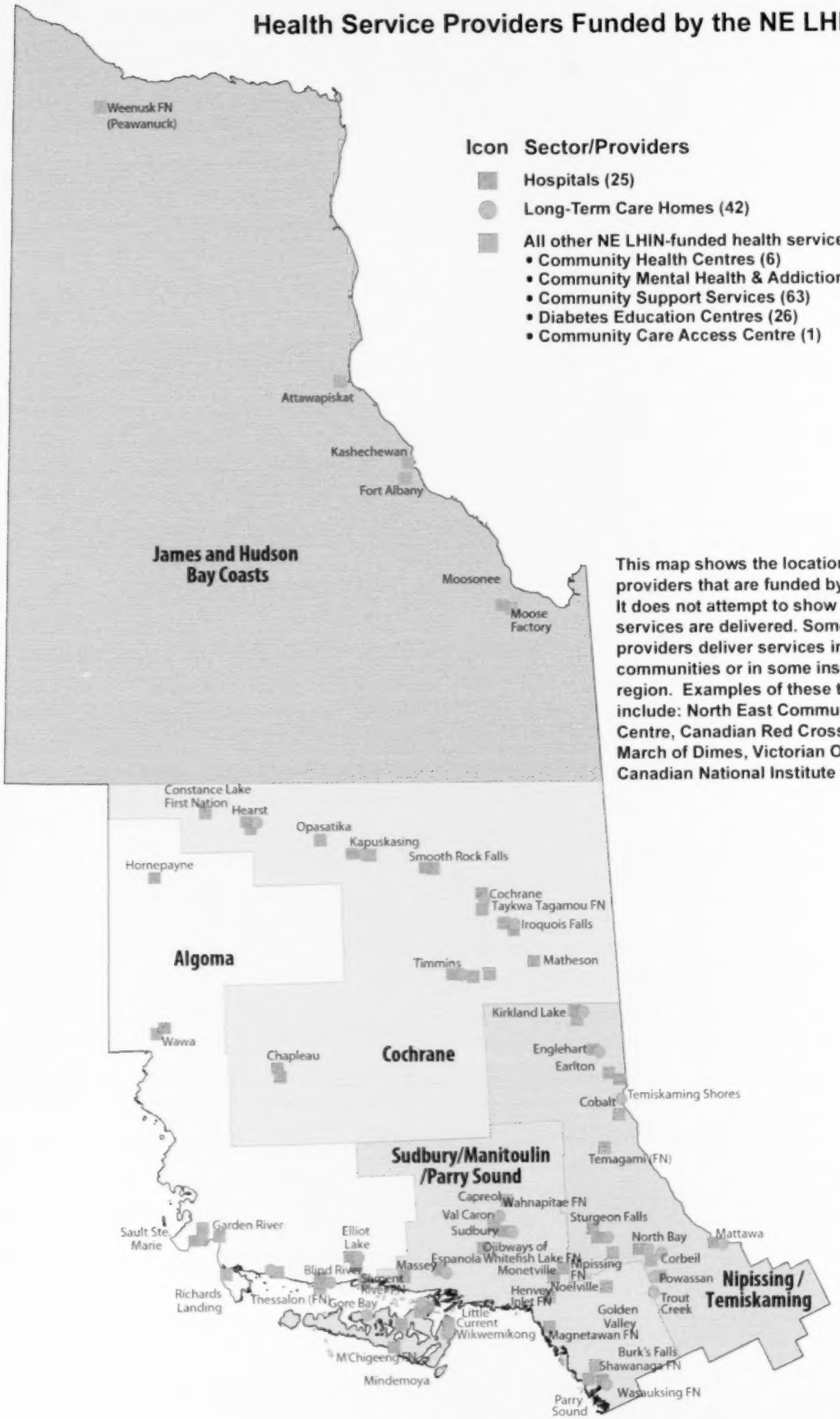
The North East LHIN region is also associated with a lower:

	North East LHIN	Ontario*
Proportion of the population who have a regular medical doctor	85.2%	90.9%
Proportion of the population rating their health as very good or excellent	57.9%	60.7%
Proportion of population reporting physical inactivity	44%	49%

(The information above is from Statistics Canada - both the 2011 Census and the Canadian Community Health Survey, 2010)

*Ontario percentages also include Northeastern Ontario percentages.

Health Service Providers Funded by the NE LHIN



Icon	Sector/Providers
	Hospitals (25)
	Long-Term Care Homes (42)
	All other NE LHIN-funded health service providers, including: • Community Health Centres (6) • Community Mental Health & Addictions (48) • Community Support Services (63) • Diabetes Education Centres (26) • Community Care Access Centre (1)

This map shows the location of health service providers that are funded by the North East LHIN. It does not attempt to show where all health care services are delivered. Some health service providers deliver services in surrounding communities or in some instances across the region. Examples of these type of providers include: North East Community Care Access Centre, Canadian Red Cross, Ontario March of Dimes, Victorian Order of Nurses, Canadian National Institute for the Blind.

Priorities and Strategic Directions for the Local Health System

Northern voices and ideas on health care improvement are the bedrock of this Integrated Health Service Plan (IHSP).

This IHSP is the region's strategic plan for *quality health care when Northerners need it.* It has been built through extensive engagement with the people of Northeastern Ontario.

The plan also builds on the accomplishments of the NE LHIN over the past several years. It is rooted in evidence-based practice in the planning and delivery of health services, and places increased emphasis on community-based and less fragmented care, particularly for our region's seniors and frail elderly.

As we move forward over the next three years, a main area of focus will be on evidence and outcomes that are quantifiable through metrics. With a continuing focus on safety, we will work with our partners to advance the gains we collaboratively achieve.

More than 4,000 people who live and work in Northeastern Ontario contributed to this IHSP. Participating Northerners included: physicians, nurses, nurse practitioners, pharmacists, people and their caregivers, consumers of health care, mental health and substance abuse providers, health human resource professionals, Francophones, Aboriginal/First Nation/Métis people, community health care workers, and many others.

> **People told us they want an easier system to navigate and one that focuses on the needs of people, not providers.**

We worked closely with the Réseau du mieux-être francophone du Nord de l'Ontario – the French Language Health Planning Entity for the North East and North West LHINs – and our Local Aboriginal Health Committee, to ensure our region's cultural and linguistic diversity were taken into account.

We partnered with the Ontario Medical Association and the Centre for Addiction and Mental Health (Northern Ontario Area) and held jointly-sponsored engagements with physicians and mental health and substance abuse consumers.

We invited local District Social Service Advisory Boards (DSSABs), municipalities and our Public Health Units to provide input on the appropriate local health care priorities for the next three years.

Voices of Northerners...

"Please do not stick to the status quo. Our health care for complex individuals is in a crisis state in the north."

"Reemphasize the humanity of patients."

"Strengthen the community health/home care sector. This is a crucial step in keeping people home and reducing the number of ALC patients."

"I work within the system and I am willing to work toward change and improving the system."

"The system belongs to all of us."

"Educating the public and the population can improve health."

"Increase health promotion – it is less costly to create a healthy population than to treat illness."

"Improve and expedite care for seniors."

Throughout each effort to engage with Northerners, we listened and found common threads of what Northerners want and need out of their local health care system. These common threads became our priorities for 2013-2016.

Priority 1: Northerners want increased primary care coordination.

The NE LHIN met with a full range of primary care providers to look at ways and means to increase access to primary care for Northerners — strategizing on how to better integrate primary care into the full continuum of care.

Primary care is the first point of contact between a patient and the health care system.

Primary care focuses on services related to health promotion, illness and injury prevention, as well as diagnosis, assessment, treatment and management of chronic conditions.

As one Northerner said,

"the main access point should be with primary care (family doctors, health centers, nurse practitioners) and not with the hospital."

The best way to find a primary health provider is by using Health Care Connect, say City of Lakes Family Health Team doctors (from left to right) Sarah Duncan, Liisa Levasseur and Katherine Richardson.

Priority 2: Northerners want enhanced care coordination and transitions to improve the patient experience.

Through the work of the NE LHIN and local partners, health care is evolving from silos of care delivery to patient-centred care.

Several realignment efforts underway, such as the newly created Algoma Anchor Agency as well as the system realignment efforts for people living in the Temiskaming District and Cochrane Hub, are evidence of this type of collaboration taking place.

Providing the right care at the right time and in the right place is especially important for seniors and the frail elderly who rely on a strong continuum of care – from hospital to community and home.

As one Northerner said,

"I would like to see everyone that is involved with the patient being on the same page concerning the patient."

William "Bill" Lecour (left), shown with J. Ed Rose, relies on NE LHIN-funded transportation services to get to and from medical appointments.

Priority 3: Northerners want mental health and substance abuse treatment services to be more accessible.

The ease with which Northerners of all ages can access mental health and substance abuse treatment services has a significant impact on the quality of life for Northerners.

Northerners are looking for a single doorway to services, where they don't have to tell their story over and over to different providers.

More streamlined care, more integration of services, and easier ways for people to navigate the system to find the care they need, were common themes echoed by many voices at mental health and substance abuse engagements.

As one participant noted, we need to,

"promote mental health to minimize onset of both physical and mental illness."

Sudburians like Arvind Jagessar can now get urgent mental health services, away from the hospital's busy emergency department, thanks to a NE LHIN investment in community crisis intervention services.

Priority 4: Northerners want health care priorities to reflect the cultural diversity of our region's population, including Aboriginal/First Nation/Métis and Francophone people.

With 22% of our region Francophone and close to 10% Aboriginal, First Nation or Métis, it is important for every Northerner to have equal access to care.

At the best of times, it can be difficult for people to express their health care symptoms to their care provider. For people whose mother tongue is not English, or who have unique cultural beliefs, the barrier to effective care becomes even greater.

As one Northerner said,

"doctors and other healthcare professions working in Northern Ontario should be required to take cultural diversity training."

North East LHIN CEO, Louise Paquette, speaks with Margaret Wabano, 108, and Cree translator Greg Spence in Moose Factory.

Building a more integrated health care system with the needs of fellow Northerners at the centre...

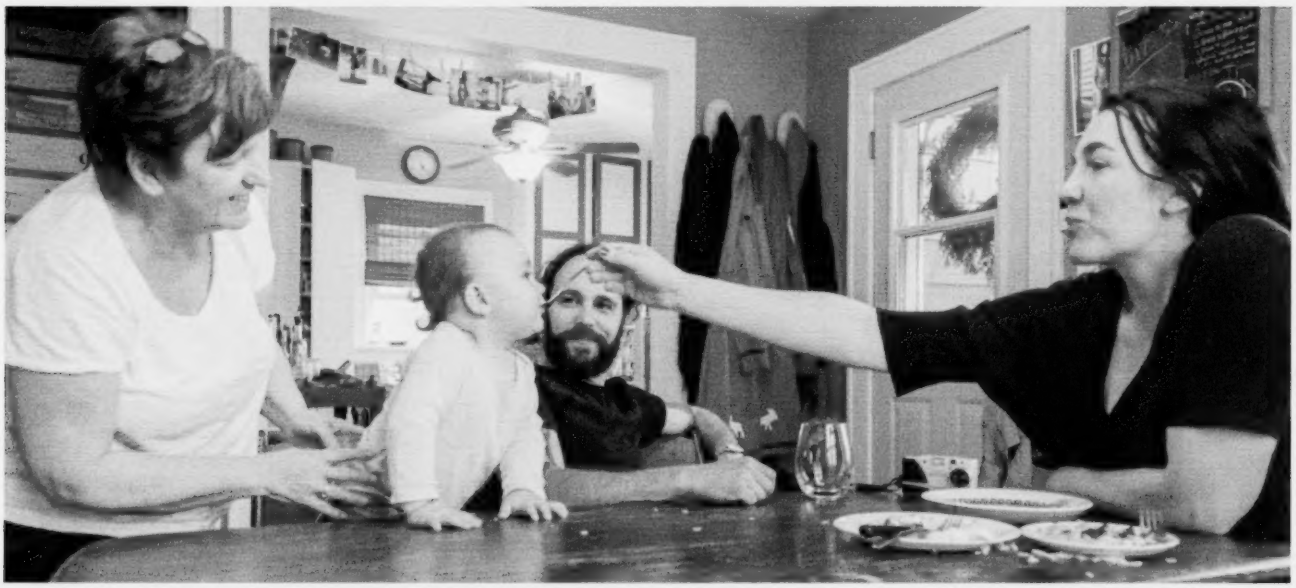
Tonia Cockburn, an Advanced Practice Physiotherapist based at the North Bay Regional Health Centre, provides comprehensive assessments to patients who may need hip or knee replacement surgery, referred by family physicians or nurse practitioners.

Five NE LHIN-funded Joint Assessment Centres now operate across Northeastern Ontario.

In this photo, Tonia discusses care options with George Lefebvre of Latchford.

People suffering from chronic hip and knee pain should ask their primary care provider (family physician or nurse practitioner) about a North East Joint Assessment Centre.

The referral form can be found on the NE LHIN website (www.nelhin.on.ca). An appointment with a Joint Assessment Centre can be set up within 7-14 days of receiving a referral.



Good diet, friends and family support, as well as healthy lifestyles, are positive practices for the prevention of illness. Generations of Northerners share dinner together -- Grandmother Donna Carroll holds baby Szabo as his mother, Shannon Dennie, feeds him and father, Billy Aulenbach, looks on.

North East LHIN IHSP Summary, 2013 – 2016

Ontario's Action Plan For Health Care

- Keeping Ontario Healthy
- Faster Access and a Stronger Link to Family Health Care
- Right Care, Right Time, Right Place

LHIN System Imperatives

- Enhance Access to Primary Care
- Enhance Coordination & Transitions of Care for Targeted Populations
- Implement Evidence Based Practice to Drive Quality and Safety
- Holding the Gains

North East LHIN Priorities

- Increase Primary Care Coordination
- Enhance Care Coordination and Transitions to Improve the Patient Experience
- Make Mental Health and Substance Abuse Treatment Services More Accessible
- Target the Needs of Culturally Diverse Population Groups

By 2016, the North East LHIN will:

- Improve access to high quality primary care for Northerners
- Improve access and quality through greater service coordination
- Improve access and system navigation for consumers and their families
- Enhance access to health care services that are linguistically and culturally appropriate
- Increase the integration of primary care within the broader continuum of care
- Improve client transitions between service providers along the continuum of care
- Increase community capacity to provide more care options for Northerners while decreasing acute sector pressures
- Increase system navigation, service coordination and access to care
- Engage and collaborate with primary care providers to better support the patient journey
- Enhance targeted service capacity where required
- Enhance care supports for people with complex issues through increased collaboration
- Increase access to mental health and substance abuse services

Priority 1: Increase Primary Care Coordination

Primary care is essential to a truly integrated, patient-centred system of care. Primary care providers play a central role in helping patients navigate the system and improve transitions between care settings, particularly for seniors or people with complex needs. Providers are essential to the transformation of our health system, whether it's taking more responsibility for keeping people well, screening them appropriately for chronic diseases or managing their care when they are sick.

Greater involvement of primary care providers to improve system integration contributes to a more appropriate use of other care settings by helping people get the right care, in the right place, at the right time. Collaboration between primary care and other providers helps people living with chronic health conditions and places an emphasis on prevention, coordination and support for self-care.

In the past year alone, the NE LHIN engaged with more than 500 primary care providers including physicians, nurse practitioners, pharmacists and others in order to seek input on how to strengthen primary care access in Northeastern Ontario. Feedback from engagements outlined the need for a more effective and integrated system that uses health care resources more effectively while focusing more on the needs of people and patients. There was consensus around the need for local (sub-LHIN) partnerships or networks based on geography that would help to deliver better value for money, ensure higher quality of care, and improve access.

Evidence for Priority

Optimal access to quality primary care services is a key determinant of Ontarians' health outcomes (HQO Monitor).

Primary care is the cornerstone and point of entry to the health care system and the place where the majority of health services are initiated and coordinated.

Primary care focuses on services related to health promotion, illness and injury prevention, as well as the diagnosis, assessment, treatment and management of chronic conditions.

Dr. Alan McLean, NE LHIN Primary Care Lead and a long-standing family physician in Sault Ste. Marie, is helping to strengthen and align access to primary care across Northeastern Ontario.

Engagement sessions also highlighted the need for a renewed primary care focus on post-acute and transitions of care beyond the hospital. This is important given the aging of the NE LHIN population and the fact that seniors tend to be high users of the health care system.

Having a strong and integrated post-acute system of care is pivotal to enabling seniors to convalesce in the comfort of their own home or preferred setting and to live independently longer, with the proper care supports around them.

When patients have faster access to care, they stay healthier, get connected to the right care provider more quickly, and are less likely to require treatment in hospital.

Primary Care: Goals and Measurements of Success

Goals	Actions	Patient Outcomes	Metrics
Improve access to high quality primary care for Northerners	Promote Health Care Connect and work to increase patient rostering. Maximize scope of practice opportunities and strategies. Promote Advanced Access and after hours care. Continue to expand telemedicine within primary care settings. Promote opportunities for inter-disciplinary collaboration.	Northeastern Ontario residents are able to access care when they need it.	Increase usage of Health Care Connect by residents and Primary Care Providers. Decrease in the number of CTAS IV/V ED visits. Reduced 30-day hospital readmission rates for select conditions. Increase in the number of Ontario Telemedicine Network (OTN) connections and consultations in primary care settings across the North East.
Increase the integration of primary care within the broader continuum of care	Support and strengthen the role of primary care in chronic disease prevention and management (particularly for diabetes care). Ensure primary care providers receive timely patient information upon hospital discharge upon which to arrange appropriate patient follow up (particularly for high-risk patients). Facilitate linkages between primary care and community services (e.g. through the liaison of CCAC care coordinators and/or system navigators within primary care practices).	Better aligned diabetes care programs with primary care providers and patients. Ensure effective and seamless transitioning of patients between care settings and service providers. Better aligned primary care services for patients.	Increase access to more integrated diabetes programs and services. Decrease in the number of CTAS IV/V ED visits. Reduced acute care readmission rate for high-use patients. Primary care visits within seven days for high-risk patients upon discharge from hospital. Reduction in the ALC rate in acute care.
Engage and collaborate with primary care providers to better support the patient journey	Establish a North East Primary Care Advisory Council. Explore the development of additional Health Links as models of care, particularly for high users of the health care system. Focus on quality improvement initiatives that will ensure providers are equipped with current best practice guidelines that improve patient outcomes.	Increased system wide collaboration to better support the patient journey. Improved quality of, and access to, care.	Achievement of the Primary Care Advisory Council annual work plan. Number of operational Health Links Networks. Reduction in acute care admissions for chronic conditions.

Priority 2: Enhance Care Coordination and Transitions to Improve the Patient Experience

North East LHIN engagements with fellow Northerners, as well as numerous studies and reports, identify opportunities to improve the patient journey within the health system by enhancing the coordination and transitions of care between individual health care providers, organizations and sectors. This is particularly true for the frail elderly and/or individuals with complex medical conditions.

Enhanced care for our growing seniors' population is a focus that weaves its way through each of the LHIN's priorities. The NE LHIN continues to facilitate change with providers to ensure seniors and the frail elderly benefit from a strong continuum of care.

Over the past several years, the NE LHIN, in partnership with community stakeholders, has made significant investments to build community capacity. Some investments include: more assisted living services, Home First and integrated discharge planning in four large hospitals, assess and restore programs, geriatric emergency management nurses and system navigators in hospital emergency departments, additional community support services, and additional long-term care bed capacity.

Evidence for Priority

- Enhancing the Continuum of Care, Dr. Ross Baker, November 2011.
- Caring for Our Aging Population and Addressing Alternative Level of Care, Dr. David Walker, June 2011.
- Ontario's Action Plan for Health Care, January 2012.
- NE LHIN 2012-13 Operational Plan.

For the Spilchuks of North Bay, staying in the comfort of their own home is important. The NE LHIN supports numerous efforts to ensure smoother transitions of care from hospital to home and between different health care providers so that our region's seniors benefit from living in their place of choice as long as possible.

While these investments have increased community capacity, notably for seniors and the frail elderly, they alone are not enough to support the increasing numbers of elderly people projected for Northeastern Ontario. The care of seniors is an area of focus in the NE LHIN's efforts to enhance coordination and transitions of care.

According to a 2010 study by the Canadian Health Services Research Group, about one per cent of Ontario's population accounts for 49 per cent of hospital and home care costs; 10 per cent of the population accounts for 95 per cent. This high-user group reflects a population that accesses care in a largely uncoordinated and fragmented manner. Evidence has shown that initiatives undertaken outside of an acute care setting, aimed at providing intensive case management support, help this high-user group navigate the system in a more efficient and effective manner.

In our engagements, Northerners strongly expressed a need for enhanced transportation services. This includes moving and supporting patients – including the elderly who no longer drive – from home to medical appointments, as well as between health service providers, such as hospitals, when required.

Transitions of Care: Goals and Measurements of Success

Goals	Actions	Patient Outcomes	Metrics
Improve access and quality through greater service coordination	Expand patient navigation in hospital and community. Develop strategies to minimize avoidable (re-) hospitalization for high-risk / high-use patients. Implement best practices in patient risk assessments and integrated discharge planning. Develop one point of access for community support services per HUB.	Improved coordination and navigation of the health care system. Effective identification and support for high-risk clients/patients. Simplified access to community support services.	Increase in number of CCAC care coordinators linked to primary care providers. Increase in number of unplanned hospital admissions screened for risk of readmission using a standard risk assessment tool. Decrease time from referral to CCAC to acute care discharge. Reduced acute care readmission rate for high-use patients.
Improve client transitions between service providers along the continuum of care	Streamline client assessments between providers. Ensure timely sharing of patient information as high-risk clients/patients are discharged from hospital. Partner with primary care providers on continuity of care post-hospital discharge. Educate patients/clients/caregivers on service availability and options. Continue to build on Resource Matching and Referral work to use LEAN techniques to efficiently move people throughout the health system. Continue to implement initiatives to support more senior friendly hospitals.	Decreased repetition of client/patient assessments. Greater linkage between hospital and primary care. Increased patient safety.	Roll out of integrated assessment record. Standardized electronic hospital patient discharge summaries to primary care providers. Increase linkages to primary care providers for patients discharged from hospital. Increase primary care visit within seven days for high-risk patients. Reduced length of stay in hospital. Availability of medication reconciliations for all patients being discharged from hospital. Health Care Connect linkage for unattached patients leaving hospital. Reduction in the ALC rate in acute care.
Enhance targeted service capacity where required	Expand regional North East Specialized Geriatric Services (NE SGS) and support local geriatric service expertise. Create new service delivery models to better meet the needs of seniors in their own homes. Expand affordable seniors' assisted living services. Develop the range and capacity of end of life services (hospice palliative care) across the North East. Implement a model for non-urgent inter-facility patient transportation across region. Continue to implement BSO Action Plan.	Enhance capacity where residents say it is most required. Allow people to stay at home as long as possible and/or avoid hospitalization when not necessary. More effectively move non-urgent patients between hospitals and avoid ALC designations where possible.	Local geriatric networks established in the four HUB communities (and linked to the NE SGS). More clients served in their homes by the NE CCAC and community support services. Increase in the number of end-of-life cases occurring in settings other than hospitals. Reduction in ALC days due to patient transfer delays.

Priority 3: Make Mental Health and Substance Abuse Treatment Services More Accessible

The NE LHIN engaged more than 225 consumers, mental health and substance abuse treatment providers and people from across the region to help inform this priority. The engagements included a variety of small group, teleconference, video-conference, webinar sessions and on-line surveys.

Given the prevalence of mental health and substance abuse issues across the system, NE LHIN engagements with other specific groups (primary care, Francophone, Aboriginal/First Nation/Métis) brought additional valuable insights and suggestions to this priority.

As well, key documents consulted closely included local needs assessments, the province's ten year strategy *Open Minds, Healthy Minds* and the Mental Health Commission of Canada's *Changing Directions Changing Lives*.

Kaarina Ranta, Warm Line Peer Support Worker, talks to a client. She is one of about 20 workers taking calls throughout the North East. The NE LHIN supported Regional Warm Line provides Northerners in need of mental health, addictions or other support with after-hours access to counseling services. Operated by the Northern Initiative for Social Action (NISA), the telephone line offers peer support for anyone needing a friendly ear. The Warm Line also empowers people with lived experience by providing employment opportunities.

Open 6 p.m. to 12 a.m., seven nights a week, Northerners can access the Warm Line by dialing 1-866-856-9276.

Evidence for Priority

In 2010/11, there were 19,646 unscheduled ED visits for North East LHIN residents with a Mental Health/ Substance Abuse (MH/SA) condition in any of the diagnostic fields.

For North East LHIN residents aged 15 and older, the rates of mental illness hospitalizations, and patient days in 2010/11, were significantly higher than provincial rates.

In 2010/11, the rate of self-injury hospitalizations for North East LHIN residents was second highest in the province, and was significantly higher than the provincial rate.

The above points are based on information in the National Ambulatory Care Reporting System, the Ontario Mental Health Reporting System, ConnexOntario Health Services Information, and the Canadian Institute for Health Information Health Indicators.

Mental Health and Substance Abuse: Goals and Measurements of Success

Goals	Actions	Patient Outcomes	Metrics
Expand system realignment initiatives by HUB to improve access and system navigation for consumers and their families	Leverage the use of new technologies and improved communication processes. Support expansion of OTN technology to substance abuse treatment and mental health services. Use a "tiered" approach to service provision that places consumer needs at the centre as per the provincial ten year strategy. Explore and implement models that streamline processes for access to services. Implement Mental Health CritiCall in hospitals. Hold a Mental Health Forum to inform how to move collaboratively forward with priority.	Improved access. Improved continuity of care. Improved access to care. Improved consumer experience. Improved access and consumer system navigation. Improved access to inpatient mental health and substance abuse services and improved health outcomes.	Ontario Telemedicine Network sites dedicated to mental health and substance abuse clinical activity, with a minimum of 8 new sites in 2013. Reduced repeat mental health and addictions visits to emergency departments. Increased number of new initiatives to reduce mental health and substance abuse revisits to hospital. Mental Health CritiCall is implemented in NE LHIN.
Increase community treatment capacity to provide more care options for consumers and their families while decreasing pressures on the acute sector	Work with partners to develop programs that incorporate the use of peer support workers, where possible. Realign resources to enhance community mental health capacity. Implement the use of quality of service indicators to monitor client/consumer treatment experience. Engage with primary care physicians on effective ways to integrate mental health and substance abuse treatment services into their practice. Implement the opiate treatment strategy.	Improved access to care that is supported by people with learned experience. Improved continuity of care Improved access to community treatment. Treatment experiences continuously improve. Improved consumer access to primary health care support. Improved treatment outcomes and support for pregnant and parenting women and other individuals with opiate dependence issues.	Increased numbers of peer support worker programs. Increase in mental health and substance abuse resources reallocated to community treatment programs. New quality of service experience indicators are implemented. Increased initiatives within primary health care. Implementation of opiate treatment strategy.
Enhance care supports for individuals with complex issues by working closely with health community sectors, ministries and governments	Implement provincial guidelines for individuals with dual disorders. Work in collaboration with partners - including Education, Ministry of Children and Youth Services, and children's mental health services - to support the implementation of approaches to helping transitional aged youth. Work with partners to implement BSO plan. Work with the Regional Human Service Justice Coordinating Committee and implement initiatives to assist individuals with mental health and substance abuse issues at risk of coming into conflict with the criminal justice system. Implement initiatives that place nurses with mental health expertise in school boards.	Improved youth and family navigation through youth transitional years. Improved treatment outcomes. Reduced risk of conflict with criminal justice system. Faster access to high-quality services, early identification and support, and help for vulnerable kids with unique needs. Enhanced caring for older adults with behavioural issues and a stronger support system for caregivers.	Region-wide implementation of provincial guidelines for dual disorders. Number of initiatives implemented to assist youth through transition from youth to adult services. Increased BSO client-based services delivered. Increase partnerships and initiatives implemented. Increased youth assessed early and provided with treatment plans, and youth experiencing smoother transitions back to school following hospitalization.

Priority 4: Target the Needs of Culturally Diverse Population Groups

Aboriginal/First Nation/Métis People

The Aboriginal/First Nation/Métis population conservatively represents 10% of the overall North East LHIN population. The NE LHIN continues to focus on building meaningful relationships with Aboriginal/First Nation/Métis communities in an effort to improve the services and the health status of this population. The needs of Aboriginal communities across the region continue to be significant in scope and magnitude.

The main objective for targeting the needs of this population group is to improve health status and health outcomes by aligning existing Aboriginal/First Nations/Métis regional, provincial and federal health planning, program and service delivery structures.

Community engagements with the Aboriginal/First Nation/Métis community were held in NE LHIN areas – Sudbury, Sault Ste. Marie, Timmins and North Bay.

Rita Wemigwans, a happy client of the NE LHIN-funded mobile day program offered in Manitoulin Island communities.

A special engagement with Dr. Sinha, Provincial Seniors Care Strategy Lead, was also held with Aboriginal health leaders.

Among our Aboriginal population, many people are aging faster than the rest of the population, due to high rates of chronic diseases. Care needs to be extended to this younger group of older adults.

The NE LHIN participated in priority setting engagements in James and Hudson Bay coastal communities, led by the Weeneebayko Area Health Authority (WAHA).

Evidence for Priority

Aboriginal/First Nation/Métis people have higher rates of chronic disease and co-morbidities and at a younger age than their non-aboriginal counterparts.

Aboriginal/First Nation/Métis people continue to have a lower life expectancy rate, a higher infant mortality rate, higher rates of suicide and higher rates of infectious disease.

Percentage of Aboriginal Population by NE LHIN Planning HUB (Census 2006**)	Total Population	Aboriginal/First Nation/Métis population	% of Aboriginal/First Nation/Métis Population
Algoma	117,461	12,925	11%
Cochrane	84,857	9,915	11.68%
James Bay and Hudson Bay Coast***	N/A	N/A	N/A
Nipissing and Temiskaming	125,843	9,305	7.39%
Sudbury, Manitoulin and Parry Sound	223,083	19,335	8.67%

Due to incomplete enumerated Indian reserves and Indian settlements, some data is not available in the Census. The total NE LHIN Aboriginal data and specifically the James Bay and Hudson Bay Coast Hub is impacted by this unavailability. ***At the time of this report, the 2011 data was unavailable.

Target the Needs of Culturally Diverse Population Groups (Aboriginal): Goals and Measurements of Success

Goals	Actions	Patient Outcomes	Metrics
Enhance access to health care services that are linguistically and culturally appropriate and deemed culturally safe* for Aboriginal/ First Nation/Métis population	Year One: • Determine the location and number of health service providers (HSPs), who have participated in cultural safety training or are experiencing language barriers and would benefit from training. • Work with partners, notably LAHC members, to develop an indicator to include in HSP 2014/15 accountability agreements that measures HSP participation in education of culturally safe services and sharing of best practices. Year Two: • Work with providers to determine and implement methods of providing cultural safety training. • Include and monitor indicator in S-AAs.	Aboriginal/First Nation/ Métis patient needs will be better met through more appropriate linguistic and culturally sensitive services. Improved health outcomes by the Aboriginal/First Nation/Métis population due to increased access to primary care services in an appropriate language and culturally sensitive manner.	Year One: • Complete inventory of HSPs participating in cultural safety training and/or experiencing language barriers. • Indicator developed to include in service accountability agreements in 2014/15. Year Two: • Indicator included in S-AAs. Year Three: • Increase HSP participation in linguistic and culturally sensitive training.
Increase service coordination, system navigation, and access to care for Aboriginal/ First Nation/ Métis population	Formalize partnerships between Aboriginal health service providers and non-Aboriginal providers within and across sectors. Initiate efforts to collaborate and create protocols between the provincial/federal governments to increase coordination of transportation services. Monitor and maximize the availability and usage of telemedicine locations and services, particularly for remote and isolated communities	Improved access, quality of care and health outcomes for Aboriginal/First Nation/Métis population that is seamless, responsive, patient-centred and provides options for remote and isolated First Nation communities.	Increase each year in the number of formal partnerships between Aboriginal and non-Aboriginal health service providers. Relationships built with federal government yielding protocols that result in additional transportation services. Increased use of telemedicine locations and services, particularly for remote and isolated communities.
Increase access to mental health and substance abuse services for Aboriginal/ First Nation/ Métis population	Implement recommendations of the NE LHIN Aboriginal Mental Health and Addiction Strategy with particular attention to traditional healing and cultural treatment methods. Align Aboriginal/First Nation/Métis mental health and substance abuse treatment services, as outlined in the NE LHIN Mental Health & Addiction strategy and decision making framework.	Improved access to mental health and addictions/ substance abuse services that includes traditional healing and cultural treatment methods. Realigned community support services that better support transitions from mental health and addiction services to community services.	Improved wait times and access to mental health and addictions/ substance abuse services. Implement Aboriginal Mental Health and Addiction Strategy recommendations. More streamlined and realigned mental health and substance abuse treatment services.

**Culturally safe services means that health service providers recognize and respect that a patient has cultural practices and beliefs and will not judge, stereotype, assume, or discriminate.*

The NE LHIN and the Réseau du mieux-être francophone du Nord de l'Ontario (RMEFNO) – the French Language Health Planning Entity – engaged with hundreds of Francophones across the region, either in person or through an on-line survey. Participants confirmed that French-language services (FLS) need to remain an integral priority in 2013-2016 and must be reflected in all LHIN activities to meet the needs of Francophones living in Northeastern Ontario.

During ten community engagement sessions, participants were asked questions about access needs and solutions relating to French-language services.

The main themes that arose in engagements and which are reflected in the goals and actions for this priority involve issues related to:

- a need for more focus on a culturally and linguistically sensitive local health care system
- primary care
- community support services
- mental health and substance abuse services, especially in rural and remote areas
- challenges to receiving services in French across the continuum of care
- the need for improved coordination of care among providers capable of offering services in French
- the shortage of French-speaking health human resources.

Evidence for Priority

NE LHIN has the largest proportion of Francophones in Ontario (about 22%).

53% of Franco-Ontarians say they have one or more chronic diseases, but in Northeastern Ontario, 62% say they have one or more chronic diseases (The Health of Francophones in Ontario, 2012 Report, Réseau de recherche appliquée sur la santé des francophones de l'Ontario).

Percentage of Francophone Population by NE LHIN Planning HUB (Census 2011)	Total Population	Francophone population	% of Francophone population
Algoma	115,870	7,410	6.40%
Cochrane	77,831	36,395	46.76%
James Bay and Hudson Bay Coast	5,407	30	0.55%
Nipissing and Temiskaming	125,954	27,915	22.16%
Sudbury, Manitoulin and Parry Sound	226,082	48,335	21.38%

Seniors Yvette Plante, Aline Seguin, Denise Bundy and Gery Berthelot play cards at the Centre de santé communautaire du Grand Sudbury.

Target the Needs of Culturally Diverse Population Groups (Francophones): Goals and Measurements of Success

Goal	Actions	Patient Outcomes	Metrics
Enhance access to primary health care services that are linguistically and culturally appropriate	Continue to work in partnership with health service providers (HSPs) to increase access to primary care services in French. Consider and include the needs of Francophones and French-language services in the local planning of primary care, health promotion/prevention and chronic disease services. Improve service coordination among primary care providers.	Decreased fragmentation of services in French. Improved access to French services across the primary care sector.	Francophone high users are identified by HSPs. Increase use of telemedicine sites to maximize access to care in French. Diabetes and other chronic disease programs offer services in French.
Improve system navigation and service coordination across the continuum of care for Francophones	Work with regional providers to include the needs of Francophones in local community care planning and to ensure greater access to French-language services. Increase access to day programs for Francophone seniors, to respite programs for their families, and to transportation programs offering services in French. Review French-language service capacity in long-term care (LTC) homes and increase the number of designated LTC providers.	Francophone patients/clients have equal access to services offered by regional and local providers, in their language of choice.	Increase the number of HSPs designated as providers of French language services (under the FLS Act) from 40 to 45. Increase the number of HSPs who implement active offer guidelines for French language services. Increase access to community support services in French, such as: day, respite and transportation programs for seniors. Increase the capacity for services in French in long-term care facilities.
Increase access to mental health and substance abuse services for Francophones	Increase the coordination and integration of mental health and substance abuse services in French. Continue to work in partnership with HSPs to increase access to mental health and substance abuse services in French. Review the availability of French-language services in the mental health and substance abuse sector.	Francophones have full access to mental health and substance abuse services, in their language of choice.	Decrease repeat visits to designated hospital ERs for Francophones presenting mental health and substance abuse issues.

Enablers

Each one of our priorities is supported by technology (electronic health records), efforts to better realign our health care system, as well as recruitment and retention of health human resources.

The following pages outline how each enabler will support the NE LHIN's work and successful achievement of goals over the next three years.

Dr. Samir Sinha, Provincial Seniors Care Strategy Lead, met with hundreds of Northerners in September 2012 to get their input into the development of the provincial Seniors Care Strategy.

In addition to his public engagements, Dr. Sinha also met one-on-one with fellow Geriatrician Dr. Jo-Anne Clarke. Dr. Clarke heads up the North East Specialized Geriatric Services based in Sudbury.

Dr. Sinha and Dr. Clarke discussed many aspects of geriatric care including the use of telemedicine to reach more Northerners through the Specialized Geriatric Services.

The strategy, *Living Longer, Living Well* was released in January 2013 and contains recommendations to achieve Ontario's vision of being the healthiest place in North America to grow up and grow old.

Voices of Northerners...

"Need more technological access for remote communities."

"Make full use of technology to save time, money and paperwork."

"Encourage more use of services such as OTN which helps bring the specialist to the patient."

"Use volunteers in more capacities – like patient advocates."

"Need to make full use of existing human health resources in communities."

"Need more innovative strategies to augment health care in the community/ homecare sector."

"Promote multidisciplinary teams to work together versus working in individual silos."

"Need to break down existing silos between municipalities/ health care/schools – we need all segments of our society to improve communication and work together."

Enabler: Electronic Health Record Opportunities

The overarching goal of NE LHIN electronic health record efforts is: one patient, one record. This means a single point of access for services, patients tell their story only once, and service providers can securely access and share health information electronically while upholding patient privacy.

The Ministry has identified electronic health records and Information & Communication Technology (ICT) as key focus areas, which the NE LHIN continues to support through its IHSP priorities and goals.

Electronic health records and ICT are key enablers to achieve goals within the 2013-2016 IHSP -- technology and information can: support patients to become healthier; provide faster access and a stronger link to family health care; and provide information to the right care, at the right time, in the right place.

As noted in Ontario's Action Plan for Health Care, *"When a (primary care) patient is discharged from hospital, they need to be made aware and able to access information quickly for appropriate follow-up."* Electronic health records and information management enable this access.

Comments received through the NE LHIN IHSP survey reflected the need for electronic health records as an enabler, for example, *"Technology simplifies a day for a doctor, allowing more time and better care."*

The NE LHIN's ICT Strategic Plan and a NE LHIN eHealth Advisory Council help to inform regional needs and to implement related projects. The Council will continue to ensure that the IHSP priorities are supported and enabled by information and technology.

The goals listed below will support the work of all priorities, 2013 – 2016:

Goals	Patient Outcomes	Metrics
Telemedicine	Improved access, quality of care and health outcomes.	No. of telemedicine events.
Telehomecare Program	Improved and more accessible chronic disease management.	No. of Chronic Obstructive Pulmonary Disease/Congestive Heart Failure patients enrolled.
Physician Office Integration	Reduced duplication of testing; improved report turn-around time; increased patient and primary care satisfaction.	Percentage of primary care providers receiving electronic reports (i.e. discharge summaries, lab and diagnostic imaging) and no. of hospital reports.
Deploy common assessment systems and integrated assessment record in community sector	Increased efficiency of work flow and data quality; seamless transition of patient data through the continuum; increased patient care and safety.	Percentage of health service providers that have implemented common assessment tools (12 metrics).
ALC Resource Matching and Referral	Improved access and transparency of referrals; faster discharge of ALC patients; greater standardization of business processes across 25 hospitals, LTC, home care, CCC/Rehab.	No. of hospitals that implement the minimum data set (pending funding).

Enabler: Realignment and System Transformation

The NE LHIN supports realignment initiatives that demonstrate action and a renewed coordination of health services planning. While a number of integration priorities will continue to be led by the NE LHIN, additional efforts to achieve a more seamless and patient-focused approach to health services will be driven by health care providers and community leaders.

Patient-focused integration efforts allow for a health care system that's easier for people to navigate and offers a greater possibility to maintain or enhance current service levels. Integration can happen between two service providers sharing a service, or two large providers merging together to provide a service. Both integration efforts are important and result in an easier system for people to navigate.

The NE LHIN, as a system thinker, works to break down silos between providers and increase access to care for Northerners. Since 2006, the NE LHIN has facilitated about 20 integrations.

The driving forces behind NE LHIN-supported integrations are:

- Provide enhanced patient-focused care;
- Expedite the shift to more community-based care;
- Ensure less duplication and fragmentation of services;
- Facilitate local providers in becoming more operationally efficient.

In 2013-16, the NE LHIN will continue to work in partnership with health service providers to achieve successes with the following integration projects, as well as emerging realignment efforts:

- The increased collaboration among three local hospitals and health service providers in the district of Temiskaming, in addition to the development and implementation of an integration plan for the realignment of health service providers in the Cochrane Hub. The emphasis for each realignment plan is to create a more patient-focused local system, fewer pressures on system providers, and increased access to care across the district/hub.

- The development of realignment plans for additional Hub planning areas of the NE LHIN.

- Implementation of the two early adopter Health Links in Temiskaming and Timmins, and the support of additional Health Links across the region.

- The continued development of the Algoma Anchor Agency which currently includes 13 mental health and addiction providers and one Board of Directors.

The goals listed below will support the work of all priorities, 2013 – 2016:

Goal	Patient Outcomes	Metrics
Development of realignment plans for all Hub planning areas of the NE LHIN Full implementation of Cochrane Hub and Temiskaming District realignment plans Implementation of Health Links across the region	Easier system to navigate. Fewer doors to receive care. More streamlined and integrated patient care across the continuum.	Reduced duplication of services. Increased access to care in communities. Increased awareness of where to go for care within communities across region. No. of Health Links.

Enabler: Recruitment and Retention of Health Human Resources

The challenge of having the right number and mix of health care professionals, when and where they are needed, is often cited at NE LHIN engagements. There are more than 20,000 individuals who work in health care across Northeastern Ontario, including the contracted service providers of the North East CCAC.

The appropriate mix of health human resources across the region is challenged by the aging of the health service workforce and general population, an increase in high-users of the system, and fewer professionals to deliver health care services.

Many communities in Northeastern Ontario experience ongoing shortages of health human resources. A shift to community-based care, away from institutional-based, has an impact on health resources and the community support service (CSS) workforce which delivers many of the home-based services to clients. CSS providers require a well-trained workforce to effectively care for patients in community.

The NE LHIN will continue to work with educational partners, such as the Northern Ontario School of Medicine and other post-secondary institutions, to address the chronic shortage of health human professionals. Innovative approaches to the recruitment and retention of health care professionals is a pillar for a strong local health care system.

Highlights of Northeastern Ontario's Workforce:

- Close to 1 in 3 people in our region's health care workforce (30%) are over the age of 50 (6% over 60).
- 29% of the workforce is between 40 and 50 years old and approaching retirement age.
- Only 17% of the workforce is under 30 years of age.
- Over 580 positions remain vacant in the region's health care workforce.

Source: NE LHIN HHR Inventory Snapshot Tool

The goals listed below will support the work of all priorities, 2013 – 2016:

Goals	Patient Outcomes	Metrics
Work with partners to develop a regional recruitment and retention strategy	More coordinated patient care across the continuum.	Self-sustaining: - shared external recruitment service - human resources inventory - common workforce planning mechanism Decrease in the number of vacancies. Decrease in recruitment costs. More coordinated recruitment efforts. Reduced reliance on locum coverage.
Apply HHR strategies to support increased capacity for community-based care	More sustainable workforce in home and community support services sector.	Increase in the number of front-line care providers within the community support services sector to meet growing community-based care demand.

Conclusion

The North East LHIN is working to achieve a vision of ***"quality health care, when you need it."*** That means a system without fragmentation, duplication, or gaps in service, with care organized around the individual and supported by providers who work collaboratively.

Fellow Northerners expect and deserve no less.

To achieve this vision, the NE LHIN will work in partnership with health service providers and other partners to transform the system by pursuing the priorities in this plan and developing care pathways focused on the patient. These patient-centred priorities will be enabled through strategies focusing on transportation services, the recruitment and retention of health human resources, realignment initiatives that better coordinate care, and opportunities with electronic health records and Information & Communication Technology.

With a continuing focus on evidence-based practice and safety, we will work with our partners to both hold and advance the gains collaboratively achieved.

Some of our goals are large, requiring a lot of effort by many partners, while others are smaller. Yet all have the potential to make meaningful changes in the way Northerners receive care.

We look forward to pursuing and implementing the strategies of this plan, as well as reporting our progress in an accountable and transparent way – key ingredients to building trusting relationships.

Marie Leon, CEO of the Independence Centre and Network (left), visits with Jaqueline Lepine, recuperating in the Centre's transitional care unit from a stroke. ICAN also offers congregate care apartments for high-risk seniors.

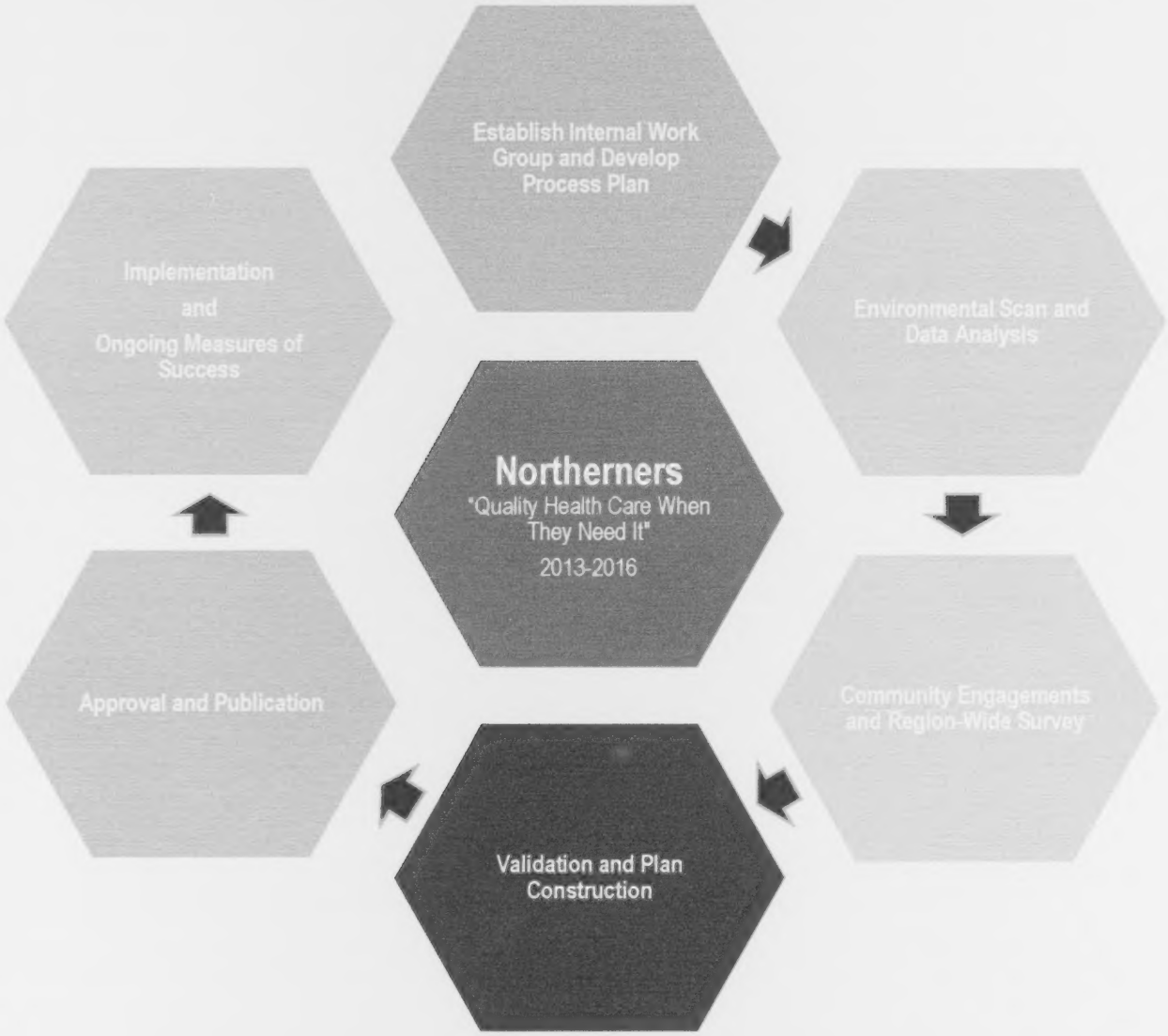
Health human resources, innovative technologies and more system integration will help to better meet the needs of Northerners in their home and/or in community.

With an increasing seniors' population, more services are needed to maintain health and wellness so that seniors can continue to live independently as long as they want to, right here in Northeastern Ontario.

Appendices

Appendix A: Methodology and Framework for Planning

The following process was used to develop and Implement this IHSP.


Establish Internal Work Group and Develop Process Plan
Environmental Scan and Data Analysis
Community Engagements and Region-Wide Survey
Validation and Plan Construction
Approval and Publication
Implementation and Ongoing Measures of Success
Northerners
"Quality Health Care When They Need It"
2013-2016

Detailed efforts to prepare this IHSP in partnership with fellow Northerners, included:

- 50 engagement sessions – some by webinar and most face-to-face – that focused on validating IHSP priorities. Hundreds of Northerners participated. These sessions were in addition to extensive engagements held in 2011 and early 2012, attended by thousands of Northerners.
- A bilingual survey that was widely publicized, showcased on our website, and attracted a total of 1,540 responses in both English and French.

- A 'virtual coffee break' by teleconference (June 2012) hosted by CEO Louise Paquette with Health Minister Deb Matthews and regional panelists to discuss Northeastern Ontario health care priorities.
- A close working relationship with the Réseau du mieux-être francophone du Nord de l'Ontario – the French Language Health Planning Entity for the North East and North West LHINs.
- A partnership with our Local Aboriginal Health Committee which includes members from across the region who represent Aboriginal, First Nation and Métis health service providers.
- More than 200 Northerners participating in meetings with Dr. Samir Sinha, Expert Lead, Seniors Care Strategy for Ontario (September 2012).
- Local analysis of an extensive collection of data informed by health statistics, Census Canada information, and other credible sources.
- Consultation of the findings and recommendations of various MOHLTC publications: ***Ontario's Action Plan for Health Care*** (2012), ***Open Minds, Healthy Minds*** (2012), ***Enhancing the Continuum of Care*** (Dr. G. Ross Baker, 2011), ***Caring for Our Aging Population and Addressing Alternate Levels of Care*** (Dr. David Walker, 2011).
- A partnership with the Ontario Medical Association to hold physician engagements.
- A partnership with the Centre for Addiction and Mental Health – Northern Ontario Area, on mental health and substance abuse engagement.
- An invitation to local District Social Service Advisory Boards (DSSABs) to provide input.
- An invitation to Public Health Units to provide input on local health care priorities.
- Helpful insights by the members of NE LHIN advisory committees who are experts/consumers in various health care areas in Northeastern Ontario.
- Guidance and direction from the North East LHIN Board of Directors.

Measuring our Success

Each priority and enabler within this IHSP has clear goals and metrics that will be applied to determine success from a patient-centred perspective.

In addition, the NE LHIN will continue to be guided by its *Annual Community Engagement Plan*, the performance indicators outlined in the Ministry-LHIN Performance Agreement (MLPA), the *Annual Business Plan* and the Ministry's *Health Equity Impact Assessment*. The Assessment is a decision support tool "*developed to support improved health equity, including the reduction of avoidable health disparities between population groups.*" The Assessment also supports improved targeting of health care investments – the right care, at the right place, and the right time.

Performance metrics will be aligned with provincial initiatives to enable benchmarking and sharing of quality improvement strategies.

The implementation of this IHSP will be flexible in accommodating additional areas of focus that may arise over the next three years further to Northeastern Ontario engagement efforts or changes to Ministry policy directions.

NE LHIN Decision-Making Framework

IHSP priorities will be implemented over the next three years in accordance with the NE LHIN's Decision-Making Framework (see below). The framework provides values, criteria and measures to evaluate new programs and initiatives, changes to existing programs, and/or integration proposals. The criteria within the framework are aligned with indicators found in the Quality Improvement Guide of the Ontario Health Quality Council.

Values	*Behaviours*
Listen	Our intention: You will be heard.
Integrity	Responsible and accountable for living our values.
Proactive	Anticipate needs & opportunities and act appropriately.
Equity	Opportunity for health & wellness for all.
Serve	Include NE Ontario geographic, cultural, demographic, and linguistic health & wellness needs in all activities.

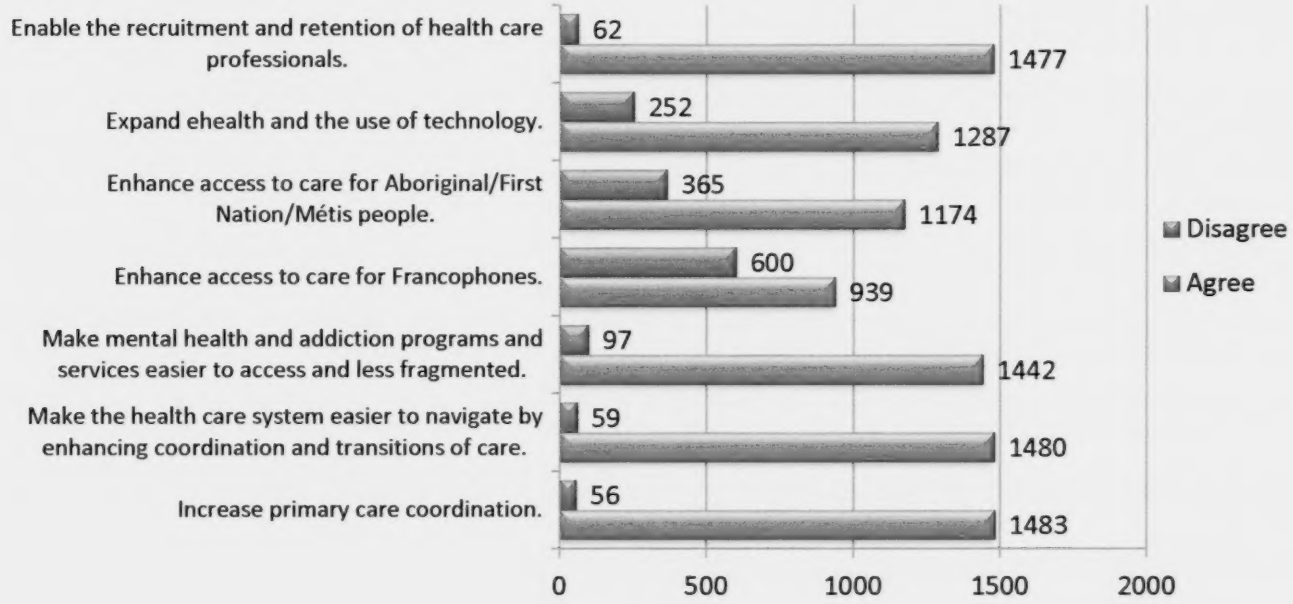
Criteria	*Measures*
Accessible	People should be able to get the right care at the right time in the right setting by the right healthcare provider.
Effective	People should receive care that works and is based on the best available scientific information.
Safe	People should not be harmed by an accident or mistakes when they receive care.
Patient-Centred	Healthcare providers should offer services in an way that is sensitive to an individual's needs and preferences.
Equitable	People should get the same quality of care regardless of who they are and where they live.
Efficient	The health system should continually look for ways to reduce waste, including waste supplies, equipment, time, ideas and information.
Appropriately Resourced	The health system should have enough qualified providers, funding, information equipment, supplies and facilities to look after people's health needs.
Integrated	All parts of the health system should be organized, connected and work with one another to provide high-quality care.
Focused on Population Health	The health system should work to prevent sickness and improve the health of the people of Ontario.

Criteria and measures as per Quality Improvement Guide of the Ontario Health Quality Council.

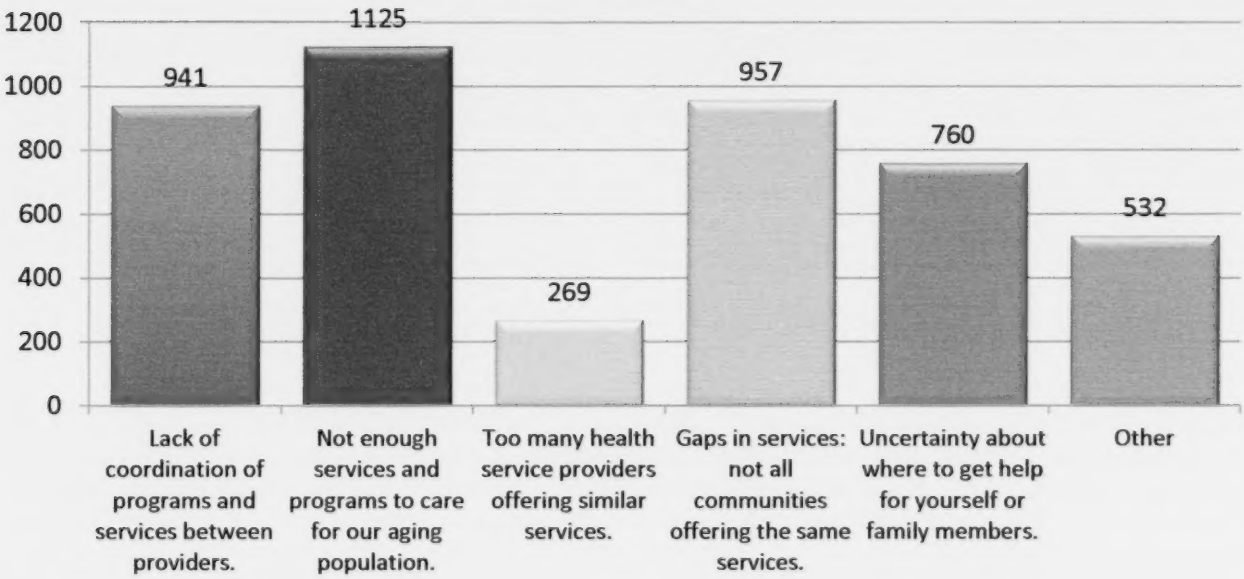
Appendix B: NE LHIN Integrated Health Service Plan Survey Results

The following charts include graphs that represent the participation of 1,540 Northerners on how to build a more local, patient-centred and integrated system of care.

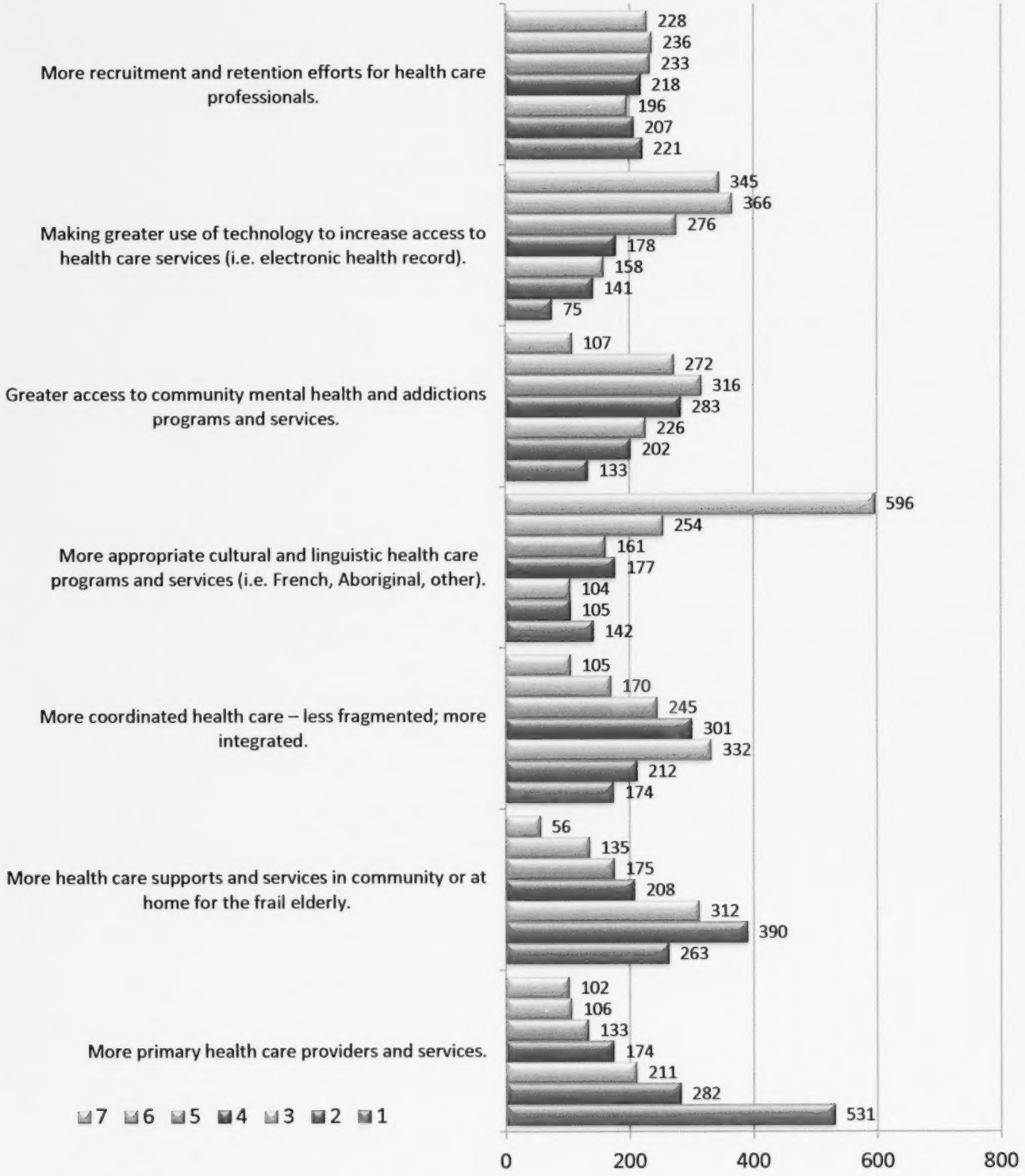
Do you agree with the following proposed list of Northeastern Ontario health care priorities for the next three years?



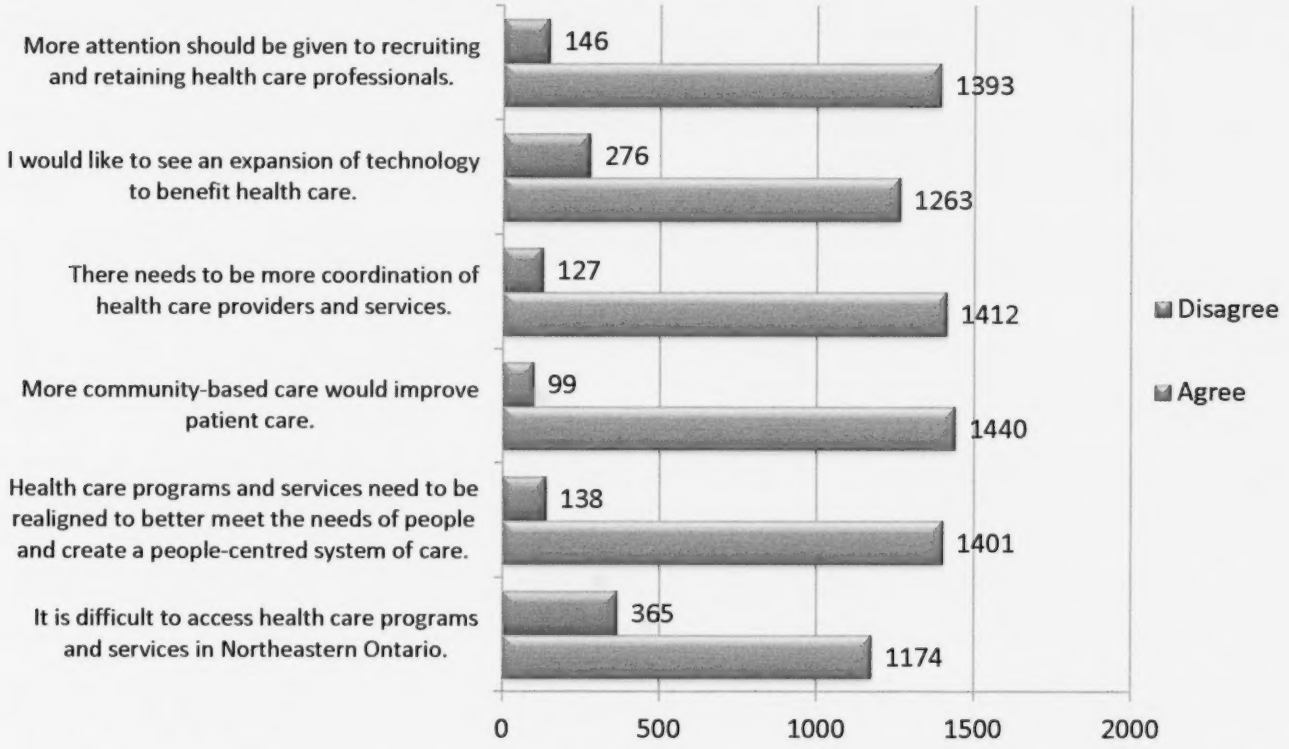
What are the greatest challenges facing health care in Northeastern Ontario today?



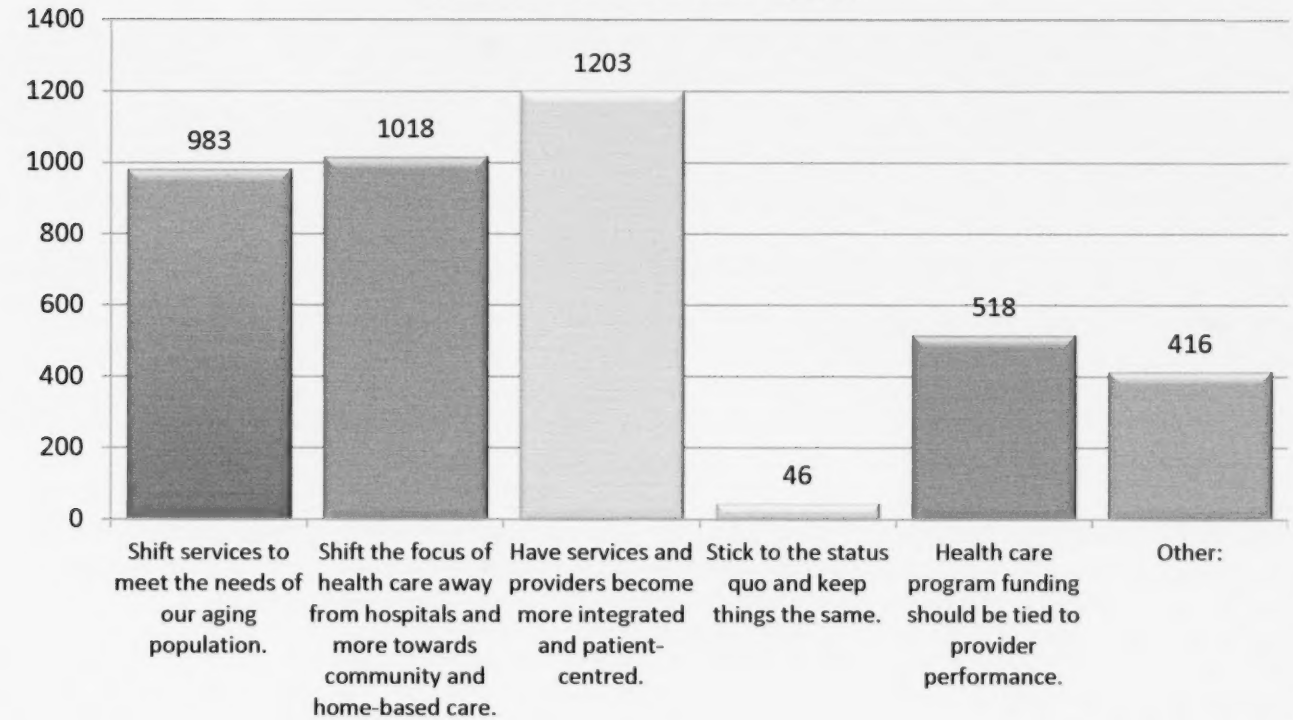
Rank the following needs from one to seven (one being most important - only use each number once) that reflect what's needed to enhance your local health care.



Indicate whether you agree or disagree with the following statements:

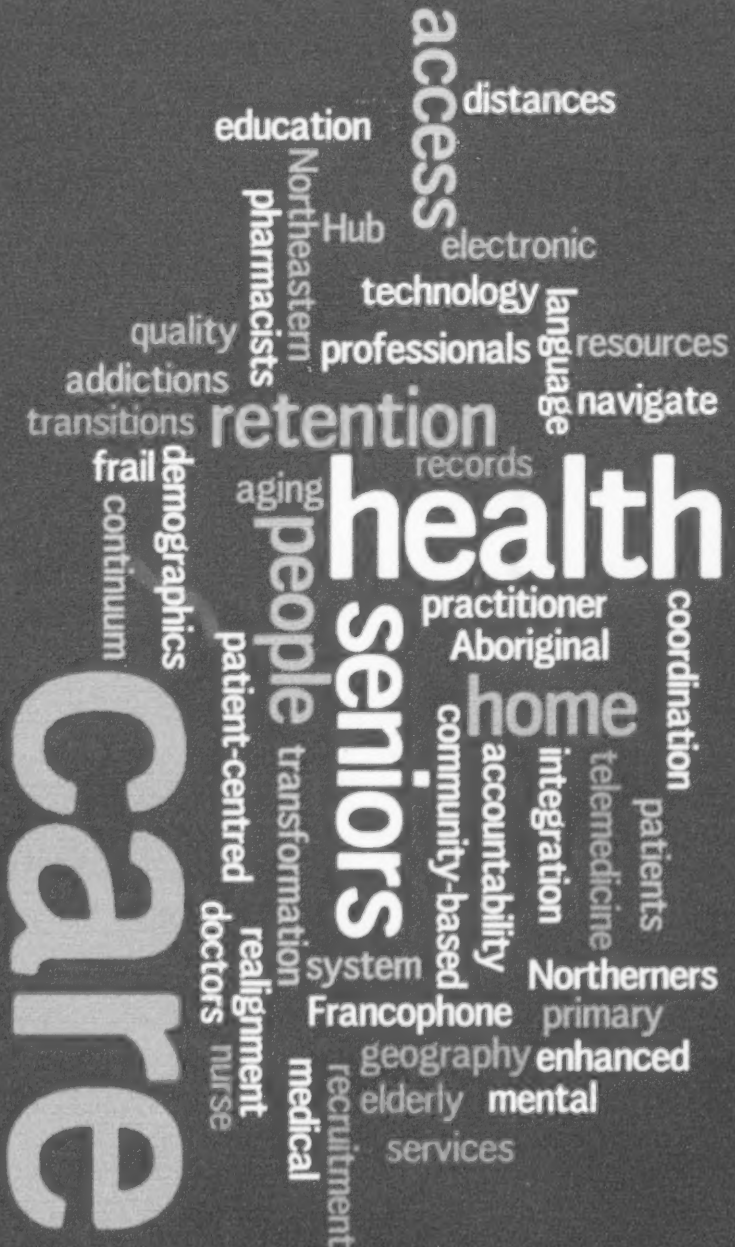

More attention should be given to recruiting and retaining health care professionals.
146
1393
I would like to see an expansion of technology to benefit health care.
276
1263
There needs to be more coordination of health care providers and services.
127
1412
More community-based care would improve patient care.
99
1440
Health care programs and services need to be realigned to better meet the needs of people and create a people-centred system of care.
138
1401
It is difficult to access health care programs and services in Northeastern Ontario.
365
1174
0
500
1000
1500
2000
Disagree
Agree

To positively influence our health care system, please indicate what you would do (Check all that apply).



Appendix C: Common Environmental Scan – A Review of Selected Information about Ontario's LHINs (September 2012)

Please refer to our NE LHIN website for this comprehensive report.



Ontario
Local Health Integration Network